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# CHAPTER 10

## Crisis and loss

Paul Morrison

### KEY POINTS

- Crisis is a normal part of life.
- A person's ability to cope with a crisis will depend on how much it is perceived as being beyond their ability to function.
- When a person is unable to deal effectively with the situation and the emotions associated with it, they may experience feelings of helplessness, anxiety, fear and guilt.
- Crisis nearly always involves significant losses (primary and secondary) for those involved, and a number of important tasks must be completed for adaptive grieving to occur.
- As people learn to cope effectively with life crises they build a repertoire of skills and competencies that can be used to manage crises that emerge later in life.
- If a crisis is not dealt with effectively it can lead to poor health.
- Nurses are frequently exposed to crisis in families and need to develop therapeutic approaches and skills to enable them to help clients.
- Helping people at times of personal crisis can be difficult and stressful for nurses and other health workers. It can raise issues and conflicts for the helper.
- Nurses need a strong commitment to cultural awareness and sensitivity when caring for clients and families from diverse backgrounds.

### KEY TERMS

- |                      |                  |
|----------------------|------------------|
| • abuse              | • loss           |
| • adapting           | • mourning       |
| • advanced training  | • nurse's role   |
| • anger              | • primary loss   |
| • assessment         | • rape           |
| • assumptions        | • rapport        |
| • attempted suicide  | • resources      |
| • conflict           | • risk           |
| • coping             | • secondary loss |
| • coping strategies  | • self-harm      |
| • crisis             | • shock          |
| • culture            | • stress         |
| • death              | • sudden death   |
| • disclosure         | • suicide        |
| • distress           | • support        |
| • emotional reaction | • trauma         |
| • feelings           | • uncertainty    |
| • grief              | • victim         |
| • helping            | • violent crime  |

- life crisis
- life events
- vulnerability

## LEARNING OUTCOMES

The material in this chapter will assist you to:

- describe some of the types of life crisis that occur and the potential impact these may have on people's lives
- understand how people deal with crisis by drawing on the resources available to them to adapt to the crisis situation, and be aware that a failure to cope may indicate a need for professional help
- identify how nurses can help clients and families deal with the types of crisis that may present in a healthcare setting
- describe nursing approaches and interventions that may be employed when caring for people and their families at times of crisis
- acknowledge the importance of cultural sensitivity and understanding for professionals when working with clients from diverse cultures at times of crisis and loss
- explain some of the vital constituents needed to establish a positive helping relationship with clients in crisis.

## Introduction

A crisis in life often appears like a bolt out of the blue. The sudden onset of illness, the loss of a job or a death in the family can visit at any time. These events can throw stable lives into a chaotic state with no apparent positive solution. This chapter examines some of the crises that can erupt without warning. It considers the defining features of a crisis and the potential impact of a crisis on people's lives.

While two people can be exposed to the same stressful event, they are likely to construe the event differently; one may be able to adapt and cope well, while the other may feel anxious and 'crushed' by the experience. It is this personal appraisal process that is at the core of coping with a crisis.

When a person is unable to cope, even for a short time, some form of professional intervention may be required. A number of crisis events are broached here, including suicide, attempted suicide, self-harm, being a victim of crime, and sudden death, with an emphasis on the important role that nurses can play in helping patients and clients to deal with these effectively. There is also a strong focus on dealing with the loss that usually trails a life crisis. The need for a heightened awareness of cultural considerations in the helping process is also stressed.

The final section of the chapter deals with some of the helping attitudes and skills that are needed to assist people to deal with crisis and loss. These look straightforward enough on paper, but in the 'disordered' environment of a busy casualty department or an acute mental health admission unit they may be much more difficult to practise and sustain. These are nevertheless required competencies for high-quality nurse-patient relationships.

## What constitutes a crisis?

Most people can recall a crisis situation in their lives that made them feel out of kilter with the world, highly anxious and vulnerable, a sense of life being out of control and unpredictable. The death of a friend or parent, being the victim of a crime, physical assault or rape, being part of natural disaster, are examples of life crises. Some types of crisis are classed as 'situational' crisis (Aguilera 1998): abortion, child abuse, rape, divorce, chronic physical or psychiatric illness, alcohol and drug abuse, suicide and attempted suicide. Others may be termed 'maturational' crisis and are linked to normal stages of development and ageing across the lifespan (Aguilera 1998). Some life crises can be anticipated (natural death of a partner), while others are unanticipated (sudden death following a road traffic accident).

A crisis can be distinguished from a stressful event that may pass quickly, such as an exam. Parry (1990) summarised the most common defining features of a crisis as follows:

- There is a triggering stress event or long-term stress.
- The individual experiences distress.
- There is a loss, danger or humiliation.
- There is a sense of uncontrollability.
- The events feel unexpected.
- There is a disruption of routine.
- There is uncertainty about the future.
- The distress continues over time (from about two to six weeks).

## Consequences of a personal crisis

A crisis will have a significant impact on the lives of those involved. It can produce great pain, distress and anguish. It can lead to feelings of unreality, uncertainty and isolation. A person in crisis will want to restore the general sense of balance in their life and feel able to cope with life again. The word 'crisis' also implies a sense of urgency, a turning point, a time for major decisions (Parry 1990). People in crisis are often in a state of shock. It is a time when their thinking is muddled and their emotional reactions are characterised by feelings of loss, helplessness and hopelessness. They may try to cope with the situation by denial initially but they need to cope in a more effective way in the long run. The role of helpers is to enable clients to cope with the problem and with the feelings the problem has elicited. The type of support offered may be emotional support, practical help, companionship, advice and information (Parry 1990).

A life crisis will stop people completing daily activities and routines. It causes a huge disruption in their lives and often the lives of those close to them. This usually means that the people involved in a crisis must make behavioural, social and emotional adjustments in their lives. These may be temporary or, in the case of a crisis brought about by the onset of chronic illness, enduring adjustments (Caltabiano et al 2002). A crisis can change a person's life permanently. It can signal the end of a promising academic career, the end of a close relationship, the inability to get married and have children, or it can heighten personal vulnerability. A crisis brings much uncertainty into people's lives because they cannot foresee how it will unfold.

At a time of acute crisis the physical environment too, such as an emergency room, may be a frightening place for patients and their relatives. The level of noise, technical equipment and activity may be daunting. In casualty, the patient who failed in their attempted suicide may feel guilty for wasting people's time. The rape victim may feel further exposed and violated. The abused child may be confused and scared and unsure of who to trust. These reactions are unlikely to be helpful at a time of acute crisis. On the other hand, strong supportive structures (families and friends) have been found to aid coping and adjustment following serious physical illness (Caltabiano et al 2002) and are likely to

play a role in adjusting following other types of crisis too.

Helping people in crisis is not about taking over (although on rare occasions this may be appropriate) and making them dependent. It is more effective to help them to use their own resources and to be supportive. It is about enabling, not disabling (Parry 1990).

## A framework for coping and adapting to crisis

How change is dealt with and the ways in which conflict and demands are handled are forms of coping. The ability to cope and tolerate these life events and incidents will be influenced by many factors which will shape feelings, thoughts, beliefs, values and actions as well as the responses of others. Crisis nearly always involves some form of significant loss for the person involved and these losses can come in many different forms—the loss of financial or personal security, sleep, appetite or the ability to think clearly, the loss of a sense of identity as a couple, a sense of trust or a sense of belonging.

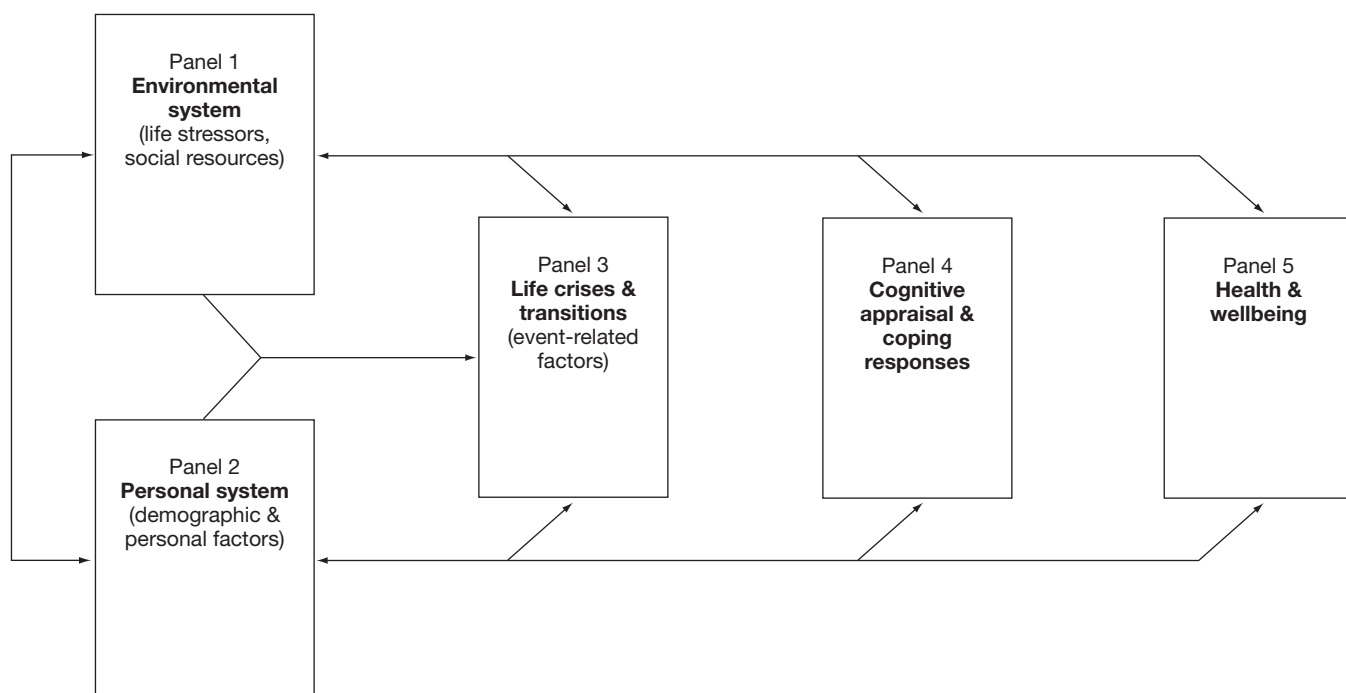
The coping and adjustment effort required may be significant and people differ in how they respond to these circumstances. The upshot of a crisis will depend on how well the person copes, and the coping process will be influenced by the interaction of ‘event’ factors, background factors, physical and social environmental factors. For example, an illness can elicit new and distressing signs such as lack of interest in personal hygiene and an inability to communicate effectively with others. Feeling angry, depressed or guilty after surviving a suicide attempt can be stigmatising

for the patient or client and reinforces their desire to hide away from people. Sometimes the disabling effect of medication side effects (such as drowsiness and drooling mouth) can be very embarrassing (Morrison et al 2000).

Some people just seem to possess an ability to find a sense of purpose or quality in their lives in spite of the awful things they come up against at a time of crisis. They can resist feeling ‘helpless and hopeless’ (Caltabiano et al 2002). Other factors that are important include age, personal beliefs, gender, personal maturity, social class and the level of religious commitment that a person holds (Moos & Schaefer 1986). These factors will shape the way individuals respond to crises (see also Ch 8, Theories on mental health and illness).

The complexity of issues, responses and settings in which crises and coping occur can be daunting. Holahan, Moos & Schaefer (1996) devised a framework for coping as a process of adaptation by drawing on earlier research and bringing together the need to consider the person and the context in which coping happens. This more general and inclusive model is depicted in Figure 10.1. It takes account of the personal and situational issues that can affect coping. Panel 1 is made up of the constant stressors in life, such as illness, as well as the supports and aids available to the person, while Panel 2 contains the person’s coping strategies and socio-demographic attributes.

These ‘systems’ influence the life crises and transitions that occur to all (Panel 3). The cognitive evaluation of these (Panel 4) has a direct impact on our health and wellbeing (Panel 5). According to Holahan et al (1996), cognitive appraisal and coping responses play a critical



**Figure 10.1** A general conceptual framework of the coping process (from Moos & Schaefer 1993)

role in responses to stress and crisis. It is also notable that the factors in each panel in Figure 10.1 can provide feedback to earlier parts of the framework, giving it a dynamic quality.

Coping strategies have been described within this framework—people typically either ‘approach’ or ‘avoid’ stressful events. This illustrates the person’s orientation. The approach or avoidance domains are also influenced by the methods of coping people can use. These are ‘cognitive’ or ‘behavioural’ methods. When combined, four basic types of coping responses (cognitive approach, behavioural approach, cognitive avoidance, behavioural avoidance) are produced (see Holahan et al 1996 for details).

Of particular importance here is the fact that the research literature indicates that consistent patterns of relationships have been found to occur using this framework. For example: ‘people who rely more on approach coping tend to adapt better to life stressors and experience fewer psychological symptoms. Approach coping strategies such as problem solving and seeking information, can moderate the potential adverse influence of both negative life changes and enduring role stressors on psychological functioning’ (Holahan et al 1996, p 29).

In contrast, people who rely heavily on avoidance coping strategies like ‘denial’ and ‘withdrawal’ tend to suffer greater levels of distress after a period of crisis. A significant body of research exploring the relationship between approach/avoidance coping and a range of clinical issues such as depression, physical illness, alcohol use and smoking behaviour, lends considerable support to this framework. It must be noted, however, that these trends might not apply across cultures.

Finally, Holahan et al (1996) also noted that people exposed to crisis events often emerge stronger and with greater levels of competence. Their ability to cope with future crises may be enhanced. They may be more self-assured and assertive, have developed different views of themselves and their abilities, achieved a new sense of purpose in life and become more resilient, in spite of the fact that they have confronted significant life crises. The framework and the findings provide nurses and other care staff with some guideposts for working with people in crisis. They present a structure to ensure that staff consider the wider canvas of events, experiences, resources and coping styles that may be at the client’s disposal with appropriate support and guidance from the nurse.

## Events and perceptions that can lead to personal crisis

Slaikeu (1990) described some of the common precipitating events that can spark a personal crisis, including pregnancy and the birth of a child, unmarried motherhood, moving from home to school or from home to university, marriage, bereavement, relocation and migration, retirement, surgery and illness, natural

disasters and rapid social and technological change. Other devastating events such as the death of a loved one or rape may elicit a crisis response. Events, even those that most are exposed to, can be interpreted as ‘the last straw’ after a crisis reaction (Slaikeu 1990).

Some time ago Holmes & Rahe (1967) devised a useful way of considering how much stress a person may be exposed to, using the Life Events Scale. The scale lists 41 positive and negative common occurrences that require adjustment and can affect a person’s risk of illness. Each occurrence is given a life-change unit score and these can be summed to reflect the level of life-changing events that have occurred in a particular person’s life in the previous twelve months. Some examples include: death of a spouse 100; divorce 73; marriage 50; change in responsibilities at work 29; Christmas 12 and so on. When these are added together a total score can be arrived at; generally the higher the score the greater the risk of illness in the future.

Even if a person with a very high score seems to be coping with significant life stresses, a major crisis (anxiety, depression, suicide attempt, heart attack) can be imminent. Within this model a collection of life-change units that amount to more than 350 in a given year may be a crisis. It is also interesting to note how even positive events (such as a promotion or a marriage) can be stressful and lead to a crisis for some people.

There are no hard and fast rules about what may be deemed a crisis and what may not. A person’s perception of events, their culture and life experience, the consequences and losses associated with these and their ability to manage effectively are primary. Scileppa, Teed & Torres (2000, p 87) commented: ‘Allowing for personal differences in coping styles, it is fair to say that any situation or combination of life occurrence that taxes individuals beyond their typical ability to function can be viewed as a crisis’.

Levine & Perkins (1997) described crisis somewhat differently, as a time when a person’s resources (material, physical, psychological) and those in the person’s social network, are overburdened. The person is unable to deal effectively with the emotions surrounding the event. They may experience feelings of helplessness, anxiety, fear and guilt, and their behaviour is ineffective. Most people cope with crises but sometimes they can lead to other problems such as abuse of alcohol and drugs, or indeed to full-blown psychological or psychiatric illness.

The nurse’s role is to help clients overcome this period in their lives, not to judge how bad things seem. Losing a pet is something most will deal with well but, for some, the loss can be followed by depression or a suicide attempt because that pet may have been the only companion in that person’s life.

The nature of any nursing intervention at this time may be centred around giving comfort, helping the person to explore their intense feelings, helping to clarify events, options for the future and sources of support—physical, psychological and social—and



trying to enhance the person's coping strategies. If these interventions are helpful then some common outcomes can be expected. The person will feel safe and well supported. Their view of the situation will be couched in reality and they will feel less vulnerable. They will be able to draw on the available sources of support and cope more effectively with the situation.

If the crisis is addressed effectively then this resolution may provide the client with new skills and competencies that can help manage upcoming life crises. If, on the other hand, the crisis is not resolved successfully then this may lead to later problems and issues that have a negative effect on the client's physical and psychological health. For example, unresolved issues may be the source of later problems in living for many victims of childhood sexual abuse who have been found to suffer from a range of negative consequences later in life, including: depression, guilt, low self-esteem, feelings of inferiority, isolation, loneliness, distrust and poor-quality interpersonal relationships, promiscuity and sexual dysfunction (Johnson 1998).

## Intervening at a time of crisis

A crisis can present in many different ways and if it is severe enough, professional helpers may be asked to intervene. Aguilera (1998) described two broad approaches to this process. The generic approach is based on the notion that certain common patterns emerge in most crisis situations and that these must be worked through if the person is to adapt in a healthy way. The intervention is aimed at achieving an adaptive resolution by focusing on the typical patterns of response in crisis rather than the distinctive ways in which individuals react (Aguilera 1998). Hence the approach is a general one focusing on the usual steps and stages that might occur following, for example, the sudden death of a partner.

The individual approach is much more psychological and focuses on the client's personal history, needs and responses. There is a greater focus on depth and human understanding, and greater levels of specialist training are required to practise in this way (Aguilera 1998). I suspect that practical reality dictates that professional helpers mingle both approaches. The typical steps in a crisis intervention scenario are outlined in Box 10.1 (see also Ch 24).

While these steps may be typical, individuals do not always pass through them in a simple linear fashion. For example, the initial assessment of the problem may be revised as the helper learns more about the client and their life over a period of time. This may change the focus of the intervention, making it more appropriate for the client's needs. Sometimes the client may set a new direction as they regain a greater sense of personal control over their lives and the coping process. It is notable that a crisis might last between four and six weeks (Aguilera 1998). In addition, many crisis situations are assessed by crisis teams. A fundamental orientation

### BOX 10.1 STEPS IN CRISIS INTERVENTION

- *Assessment*: including assessment of the potential risk to the person and others
- *Planning a therapeutic intervention*: taking account of the impact on the person and the resources available to the person
- *Intervention*:
  - Help the person to understand what has happened.
  - Help the person to express feelings openly.
  - Explore coping mechanisms.
  - Re-open the social world.
- *Resolution of the crisis and future planning*

(Source: described by Aguilera 1998.)

in psychological treatment has been emphasised by Schwartz (2000), who notes that however bizarre the client's behaviour might appear, they are human beings first and foremost, which demands that they be treated with dignity, respect and compassion. The illness is an important secondary consideration. This orientation is central to all forms of counselling and helping but it is especially important when helping very vulnerable members of society at times of crisis.

### CRITICAL THINKING CHALLENGE 10.1

You are in charge of the Crisis Assessment Team, responsible for taking calls from people who may have a mental illness. It is approaching midnight and only three staff are on duty. One of the staff, a single mother with small children, is due to finish the shift at midnight and collect her children from the babysitter. Three calls come in almost simultaneously.

- The first call is from your very good friend. She tells you that she had an abortion this afternoon and can't stop crying now. You did not know she was pregnant.
- The second call comes from the local police, who ask for your immediate attendance at a local hospital where a 22-year-old man is threatening to shoot another resident and then himself.
- The third call is from Joan, a 38-year-old registered nurse who is well-known to the service and has received treatment for depression in the past. She is obviously drunk but says she has taken 30 paracetamol tablets.

What course of action would you recommend in each of these cases?

## Crisis, loss and grief

Worden (2001) described mourning as the 'process which occurs after a loss', while 'grief refers to the personal experience of the loss'. Grief is an emotional response of distress, pain and disorganisation. Mourning involves unravelling the previous bonds between the person and a deceased person (or object or part of the person). A process of mourning is needed to overcome grief.

Grief may be elicited by many different types of loss, such as a loss of self-esteem, loss of job, loss of financial

status, loss of freedom, loss of physical abilities, loss of identity. Grief nearly always involves primary losses (death, job, relationship) and secondary losses or losses that result as a consequence of the primary loss (status, security, self-esteem). Secondary losses may not be apparent to the patient or client, and nurses can assist in the grieving process by helping the client to uncover these.

A number of key tasks of mourning have been described by Worden (2001) and these need to be accomplished if the client is to return to a state of stability. These are:

*Task 1:* To accept the reality of the loss

*Task 2:* To work through the pain and grief

*Task 3:* To adjust to a world in which the deceased is not there

*Task 4:* To relocate the deceased emotionally and move on with life.

When people are in mourning they experience feelings that are common. They may believe that these feelings are unique to them, but they are not. Acknowledging this commonality helps people to share the pain and may be facilitated through bereavement groups. Experiencing personal loss is part of what makes us human.

Grieving is a normal process after loss, and involves emotional (sadness, anger), physical (breathlessness, physical weakness) and cognitive (confusion, disbelief) sensations as well as behavioural changes (social withdrawal, crying). It can be helpful to let the client know that these are normal and that it is helpful to express and share these facets of grieving to promote healing. Remembering and talking about the lost loved one can help people to feel stronger, and Hedtke & Winslade (2004) argue that this type of narrative remembering practice has a healing and inspiring effect on those grieving.

Conflict within a family about whether a dying relative should have been told they were dying may be a source of guilt and long-lasting family disharmony. Not to tell the person prevents them from getting their house in order and many things may be left unsaid. These types of family issues can complicate the grieving and healing process and create additional pressure for the nurse.

Resources are now widely available to ensure that counsellors, professional carers and clients are better informed about issues surrounding death and dying. People with internet access can now study a wide range of information about death and dying, arguments for and against legislation on euthanasia, and information about cancer, suicide and AIDS. In addition, there is growing recognition of the need for communities to be aware of the diverse ways of grieving that different communities need to undergo and experience. NSW Health and Queensland Health have developed an online catalogue that outlines how different groups (professional and informal) in the community cope with bereavement, in an effort to provide culturally sensitive healthcare. Nurses working with culturally diverse

client groups would be well advised to become familiar with some of these resources (see Ch 7).

## Suicide and attempted suicide

One crisis situation that most nurses will come across, in both mental health and general settings, is suicide and attempted suicide. Suicide in Australia and New Zealand is a significant mental health problem, especially in young men (15–24 years), older people and people living in rural and remote areas of the country. The respective government web pages dealing with mental health make for grim reading and some strategic initiatives have been developed to address this tragic situation.

People who are seriously depressed or who express feelings of worthlessness, guilt, anxiety and anger, and display severe agitation and irritability, may be at risk of suicide. It is important to note here, however, that 'not all suicides or attempted suicides are by individuals with a clinical diagnosis of depression. Stressful and negative life events can become triggers for suicidal ideation and attempts, such as drug or alcohol abuse' (Sharkey 1999b, p 92). Mann (2002) notes that alcohol and substance use increase the risk of suicide, as does the existence of a plan and a history of attempted suicide. Other illnesses too, such as schizophrenia or bipolar mood disorder, can be prominent. Suicide is often a complication of psychiatric illness but it is usually accompanied by additional risk factors such as a genetic link with someone who has committed suicide, living in rural areas with access to guns or other lethal means, poverty, unemployment and social isolation (Mann 2002). He also mentions the fact that some of the glossy media portrayals of suicide carry the risk of copycat suicides among young people.

The primary goal of crisis management is to reduce or eliminate the risk to the clients and/or to others (Doyle 1999), whether in a hospital or a community setting. Schulberg et al (2004) found that distressed people often visit primary care staff such as general practitioners in the weeks and months before a successful suicide. In a systematic review of suicide intervention strategies, Mann et al (2005) found that the education of physicians in recognising and treating depression, and removing or restricting access to lethal means, were the most effective interventions in preventing suicide. Professionals and lay people often explain suicide and attempted suicide differently, although there is a common perception that some form of crisis has occurred in the person's life. Zadravec, Grad & Sočan et al (2006) emphasise the need for health carers to acquire a clear understanding of the beliefs of the suicidal person, which may be incorporated into the treatment and management plan.

A key role here for the nurse is to recognise the potential risk and intervene beforehand. Sharkey (1999b) extracted a number of high-risk indicators from the literature in this area. These are outlined in Box 10.2.



**BOX 10.2 HIGH-RISK INDICATORS FOR SUICIDE**

- Deliberate self-harm
- Following admission to a mental health unit, particularly during the first week
- Following discharge from a psychiatric setting, particularly during the first month
- Drug or alcohol misuse
- Recent major life event such as divorce or separation
- Being from a particular at-risk group, such as farmer or doctor, or being unemployed
- Non-adherence with treatment/medication
- Rapid change in treatment type or in accommodation setting
- Poor relationship with carers

(Source: Sharkey 1999b.)

If the healthcare team has identified a client at risk of suicide, each team member will need to work with the client at a time when the client feels desperate and hopeless and sees no end to the darkness in their life. (See also Ch 24, Therapeutic interventions.) Rapport can be established by heeding the advice offered by Wright (1993):

- *Take a threat of suicide seriously.* Individuals who have attempted suicide on a number of occasions can be ignored or dismissed as ‘attention-seekers’ and later found to have suicided.
- *Try not to be judgmental.* It is very easy to view the client within your frame of reference and assumptions and to judge their feelings and intentions accordingly, perhaps to think, ‘What’s he/she got to be depressed about with a lovely partner, family, home and a nice car?’
- *Work with the feelings raised by the client.* Stay with the patient/client’s feelings, not yours. Try not to steer the client away from their feelings: ‘It’s not that bad—I’m sure you’ll feel better in the morning’. Utterances like this may help *you* to feel better, but not the client.
- *Work with positives in a sensible manner.* Even at times of great despair and desperation it may be possible to find glimpses of positive incidents, experiences or perspectives that might be helpful. Remind the client how talking openly about their plans and intentions can be useful.
- *Accept the client’s anger.* The client may release strong emotions such as anger and it is best if this is done in a quiet and private setting where others will not be disturbed. When you recognise that it is usual for a client to express negative emotions such as anger or guilt at times of crisis, it can help you to understand and accept these uncomfortable emotional responses, even if they are directed at you.

The major challenge for the nurse is to provide a supportive relationship through which the client’s issues and perspective can be explored and fully understood by the healthcare team. This is a basis for establishing

a safety framework for the client that involves all the resources at the nurse’s disposal while treating the client in a respectful manner. This can be a challenge if the client is not very communicative.

Caring for people at risk of suicide or self-harm is emotionally demanding and stressful. It is a source of major anxiety for inexperienced and experienced nurses alike. Despite a relatively common view that talking about suicide with someone at risk is likely to urge them into action, there is no evidence to support this view. In fact, people who are thinking about killing themselves are often relieved that the issue has been broached by staff. It brings it out into the open and allows them to share their sense of dread with another human being. It is okay to ask about their plans, the resources available to the client (guns, knives, ropes, tablets) and their intentions (Wright 1993). A fuller understanding of the client will help the team to be better able to care for them and decreases the likelihood of suicide.

### Griever concerns following suicide

Loss through suicide can evoke certain types of concern in the griever (Cook & Dworkin 1992) including psychological, social and personal concerns. The psychological issues may centre on the need to understand why it happened. They may feel guilty and display a sense of failure. They may blame others in an angry way and feel totally rejected. The taboo surrounding suicide can interfere with the grieving process and may lead people to withdraw socially, and patterns of communication in families can be disrupted (social concern).

Personal concerns can include the need to deal with a sense of betrayal or a reluctance to get close to people emotionally in the future. These fears will shape the helping process following suicide as the nurse attempts to help the client complete any unfinished business with the deceased, use the support that other people and services provide, and avoid withdrawal from the social world.

### Self-harm

Some people can harm themselves deliberately (inflicting injury with a sharp object resulting from delusional beliefs) or through neglect (e.g. lack of a proper diet). People with a diagnosis of schizophrenia tend to have a higher risk of self-harm, especially when their symptoms such as delusions and hallucinations are poorly controlled. These clients have a 10% lifetime risk of suicide (Hogman & Meier 1995) and make up one in three hospital suicides (Sharkey 1999a). Some of the key strategies for managing the risk of self-harming clients from this group and those with depression have been outlined by Sharkey (1999b) (see Box 10.3 and Ch 23 for self-harm).

Sharkey (1999a) also makes the point that there has been a significant shift in the way in which risk in schizophrenia in particular is approached these

**BOX 10.3 MANAGING THE RISK OF SELF-HARM**

Crises in community settings:

- Make frequent contact (home/day centre/outpatients).
- Make rapid follow-up for failed contacts (establish an agreed team plan with clear roles and responsibilities).
- Monitor medication and use optimum dose to lift mood with minimal side effects and avoiding over-medication.
- Build a therapeutic relationship.

Crises in hospital settings:

- Provide constant supervision through close observation.
- Provide clear notes and communication.
- Clarify responsibilities with team members.
- Monitor medication and use optimum dose to lift mood with minimal side effects and avoiding over-medication.
- Use power of detention (if available).
- Build a therapeutic relationship.

Long-term management of risk:

- Work to an agreed plan for the future to identify stressors, build self-esteem and hope.
- Work with family/carers to solve problems, increase or maintain coping strategies.
- Develop structured, safe and meaningful daily activity.

(Source: Sharkey 1999b.)

days. There is a far greater emphasis on the client's experience, community care, the use of formal and informal supportive networks and combination therapies, rather than a sole reliance on medication to control the disease within a constraining environment. Schwartz emphasises that in a crisis:

it is important to remember that, no matter how bizarre their behaviour, people with schizophrenia are human beings with the same feelings, fears, desires, and hopes as everyone else (Schwartz 2000, p 371).

## Being a victim of crime

A person who has suffered some form of physical and/or psychological harm (rape, sexual assault, domestic violence, incest, assaults on children or old people) is a victim (Wright 1993). In cases where it is obvious what has happened, the police and other agencies will be involved directly. In other cases, when staff suspicions are aroused that a crime has occurred (that a child is being abused, for example), the consequences of raising these suspicions may be devastating for the family and child.

If these suspicions are correct and can be supported by evidence, a child could be spared future episodes of abuse. If incorrect, the child could be removed in error from the home, causing great distress to the child and the family. In other cases a woman may be reluctant to press charges against a partner who assaults her

routinely after drinking binges. She may believe that she has brought this abuse on herself through her own behaviour and fear that separation from her partner will result in her losing her children because she does not have a job or cannot support them alone.

Emotional and physical abuse are offensive to most people and it is sometimes difficult to imagine how some people can continue to live in these circumstances. Zink et al (2004) note the particular problem of older women (those over 55 years) who are not identified as victims of partner violence by members of the healthcare team because this issue is often perceived by staff as a problem of younger women. They claim that older women may find it difficult to raise the issue with professional carers, highlighting the need for privacy and knowledge of appropriate helping sources of referral. Abuse can raise issues for staff, too, and trigger strong emotional responses (such as anger) that interfere with their ability to care in a professional manner. These personal responses may stem from the staff member's having been abused themselves, or being a child with an alcoholic parent, and being unable to deal with these events in an adaptive way.

In an exploration of the traumas that have been found to occur in the lives of children, Johnson (1998) noted that the professional helper may have to:

- identify specific crisis situations
- recognise who is and who is not affected
- decide who is at risk in a particular situation
- devise options for managing the crisis
- intervene appropriately
- monitor post-crisis recovery
- decide when and how to follow up.

This profile of the professional's role with respect to children is typical of all crisis work. In the case of children, the identification of a crisis poses additional problems and responsibilities. A child turning up at a nurse's clinic for a consultation about head lice may be a victim of assault, rape or incest but be unable to report this due to fear of, or emotional attachment to, the perpetrator. The identification process becomes crucial here. This is why a supportive team approach is vital, as a means of ensuring that assessments are thorough and accurate, and as a means of lending support to other team members. In such cases other agencies (such as the police) are involved.

Abuse can occur in older people too. Kinnear & Graycar (1991, p 1) reported that some '4.6 per cent of older people are victims of physical, sexual or financial abuse, perpetrated mostly by family members and those who are in a duty of care relationship with the victim'. The abuse of older people has been found to occur in residential-care settings as well as private homes (Kinnear & Graycar 1991). An increase in the incidence of abuse in this vulnerable group is also likely to occur as older people comprise a growing proportion of the population as a whole. While most people in this group will live independently, an increasing minority will be dependent on relatives or residential-care providers as

their primary support, and in some instances conflict, power relationships and abuse will emerge.

As is the case with other vulnerable groups, the nature and extent of abuse of older people can be very difficult to uncover and validate. The initial contact with these clients may be coincidental (e.g. at a health centre or accident unit) and if the signs are very 'obvious' (bruising, fractures, severe agitation) then suspicions may be raised. However, an older, slightly confused person may be locked in a room all day by relatives to stop them wandering the streets, or not be allowed to drink after 4 p.m. in case of bed wetting. These restrictions too are forms of abuse and are much harder to spot unless, in the short time that a skilled and attentive nurse has with them, these older people can feel safe enough to voice some of their experiences. Then further exploration must follow.

Although the acute phase of the crimes may be seen to be 'sorted out' in a few short weeks, the aftermath may raise long-term issues requiring counselling and therapy over a period of time. A woman who has been raped may be seen by others (or herself) as a 'whore' and be ignored by her partner. A male victim of sexual assault might end up questioning his own sexual identity (Van der Veer 1998). These violations raise significant issues and personal conflicts for the victims. Jurisdictions across Australia have established specialist help lines for sexual assault and rape victims, reflecting the increased need for these expert crisis centres. Time and specialist counselling may be needed to come to terms with these significant events and their impact on all concerned.

It may be worth mentioning here that crime and violence and mental illness tend to be strongly linked in many people's minds, giving rise to unwarranted fear and prejudice about mentally ill people living in the community. This perception can influence healthcare staff too. However, most violent crimes occur between people who know each other. Non-psychiatric offenders were five times more likely to focus on people not known to them and therefore present a greater risk to the community than those with a diagnosis of mental illness. In 95% of cases where a psychiatric client has been involved in a violent crime, there has been previous contact with the victim (Pilgrim & Rogers 2003).

In stark contrast, recent research from the United States and Denmark indicates that people with psychotic illness are actually much more likely to become murder victims. One-third of people with serious mental illness were victims of crime. Of these, some 91% were violent crimes, including rape and assault. Drug users and alcoholics faced even higher risks (Cuvelier 2002).

However, there will be rare occasions when a person who is mentally ill may try to harm others, and the risk must be assessed very carefully. A new mother with severe postnatal psychosis may try to harm the new baby because she feels that the baby is trying to kill her, or an older deluded man may try to harm his wife of forty years because he thinks she is trying to poison him. While not common, these scenarios nevertheless

highlight the tension instilled into the nurse's role in assessing and managing a potentially risky situation, and the need to protect potential victims as well as those who might commit such a crime.

While very few victims of crime do actively seek treatment, Hembree & Foa (2003) note the importance of establishing a helping alliance with victims of crime such as rape, abuse or violent attacks. A helper who provides compassion, understanding and a non-judgmental attitude is likely to help in the healing process (Hembree & Foa 2003).

## Sudden death

There will be times when a client commits suicide, especially in mental healthcare, or when a patient suddenly dies, perhaps in the emergency room following a road accident. A sudden and perhaps unexpected death through suicide will be a source of great stress for staff if they have known the client and then need to support the relatives in their grief. Within the staffing group, such events can give rise to strong feelings of guilt and self-blame, personal shame, failure and inadequacy. The shock of such events can be immobilising (Wright 1993). Relatives can be overcome by emotion following unexpected death. In these cases Worden (2001) recommends that the helper begin at the crisis scene (hospital or morgue) to offer help and direction there and then. At this time people may be in a state of shock and disbelief, unable to ask for direct help, and uncertain of what to do.

Nurses in the emergency room and other settings may be called upon to: comfort a relative following the sudden death of a child, parent or partner; be an advocate for the relative; provide positive support when they appear lost and uncertain; and help in breaking and accepting bad news. On occasions, the nurse may have to support the relative to view the body and just be there for them when strong emotions and naked human distress are given a free rein (Wright 1993). Traumatic loss may be sudden and violent. It may involve bodily mutilation. It may be seen as preventable. It may be the grieving person's first encounter with a dead person.

While the circumstances of individual crises may vary—suicides, sudden unexpected deaths, accidents and trauma, children and infants, miscarriages and stillbirths—the pain experienced is traumatic and shocking for those who remain. They can be helped to begin to come to terms with this loss in a number of ways. Some of these are outlined in Box 10.4. Of course it is important to be aware that some cultural and religious practices may need to be observed. Nurses who lack experience should consult more senior and experienced colleagues and, if available, specialist helpers or advisors who know about the accepted customs of a particular cultural group.

It is also important to offer support for family members if possible because they too are often victims of social stigma because of the circumstances surrounding

**BOX 10.4 WHAT IS VALUED BY RELATIVES WHO HAVE EXPERIENCED A SUDDEN DEATH**

- Clear, unambiguous messages: 'The news is bad. Your daughter has just died'. People need to know the facts quickly.
- Confirmation: you might need to verify the facts of the death several times.
- Try to prepare yourself to answer difficult questions: Why now? Why us? Why could it not be prevented? Why could you not do more?
- It will help if relatives and friends can spend time with the deceased to say goodbye. You might have to help by saying: 'Maybe you would like to see him/her one last time before you go home'. This helps to normalise the viewing.
- Allow the relatives time and space to spend time with the body. Let them sit down. Encourage them to talk and touch the body.
- Before they go home give them some time to go back over what has happened.

(Source: Wright 1993.)

the client's death (suicide, drink driving or drug taking) (Lively, Friedrich & Buckwalter 1995).

**Parental bereavement**

Gillies & Neimeyer (2006) described how people attempt to construct meaning to help them adapt to bereavement, including attempts to make sense of the death, exploring possible benefits and considering important identity changes that might evolve. This can be particularly difficult when a child dies. In a qualitative study of parental bereavement, Wheeler (2001) found that the death of a child led to a severe crisis of meaning in parents. Many reported that they had eventually found meaning after the death through connections with people, beliefs, values and engaging in routine activities of living.

**Sudden death of a partner**

In a qualitative study of people who had lost a partner suddenly, Rodger et al (2006/07) described some of the great difficulties people experience when trying to regain a sense of functionality in their lives, and the strain this event places on their coping resources. However, they also described the new life order that emerged eventually in their lives, which was more hopeful and optimistic and future orientated. Somewhat surprisingly Carnelley et al (2006) explored the experiences of people who had lost a partner and found that they continued to think and talk about, and to feel emotions for, the deceased person, even decades after their death. Hence grieving can take many years and it is very common for people to have conversations and emotional experiences many years later.

Furman (2007) described grief and loss as a brutal force which entails great suffering and which may be followed by positive life change:

If grief and mourning are brutal teachers, they can also be silent but empowering ones. Social workers and other health professionals should not minimise the supportive roles that they often play as facilitators and witnesses in the interface of religion/spirituality, death, dying and bereavement (Furman 2007, p 110).

**Attitudes to death**

Dealing with death can be problematic, as attitudes have changed over the years. Increasingly, people now die in hospitals and nursing homes, when in the past they died at home. In addition, in Western cultures professional services are hired to look after the dying and the death, and this is very different to how things were done years ago. Then, families played a much greater role in these processes. The attitudes of people and professional healthcare staff have changed too, with the growing emphasis on technology in the health system and changing lifestyle patterns. People live longer now, and fewer people are exposed to death or to dying relatives until later in life. Jalland (1997) suggested that the emphasis in medical teams these days is on avoiding death through scientific expertise rather than on providing comfort to the dying. Yet Kübler-Ross (1981) argued that dying can provide important lessons for professional staff and for the families of the deceased.

**Crisis, loss and culture**

Dealing with the losses associated with a life crisis has been referred to as 'grief work' (Levine & Perkins 1997). Moos & Schaefer (1986) described a number of tasks that need to be worked through to help people adapt effectively:

- to find meaning in the event and understand its significance for the person(s)
- to face up to the reality and manage the demands of the situation
- to sustain interpersonal relationships
- to preserve an emotional balance
- to uphold a satisfactory self-image and keep a sense of self-efficacy.

Working through these tasks enhances a person's ability to cope. However, this process is made much more complicated (for carers and clients) when different cultural groups are involved. Culture refers broadly to patterns of attitudes, beliefs, values, behaviours and knowledge that are shared by people from particular social groups and which evolve over time. These become a general blueprint for people's actions and reactions to their experiences and to the crisis points in their lives. In some cultures, for example, community members will feed and support a recently bereaved person (Wright 1993). In some societies, psychotic behaviour can be a sign of special powers and abilities (Helman 1990). Cultural norms dictate how a particular situation or experience is defined and understood (Robbins 1997) (see also Chs 6 and 7).



CRITICAL THINKING CHALLENGE 10.2

Complete the following questionnaire on personal vulnerability.  
Answer each question: **Y** = Yes, I agree; **P** = Perhaps, I'm not sure; or **N** = No, I disagree.

	Y	P	N
1 It's hardly worth working hard in your job since most times other people get the benefits of it.	—	—	—
2 I like it when something unexpected happens to break up the routine of the working day.	—	—	—
3 When someone in authority has made a decision there's not much you can do about it.	—	—	—
4 I've found that most of my misfortunes have happened because of mistakes I've made.	—	—	—
5 Life is an interesting adventure.	—	—	—
6 It upsets me a great deal if other people get annoyed with me.	—	—	—
7 If someone has it in for you there's not much point in trying to reason with them.	—	—	—
8 Every problem has a solution.	—	—	—
9 I often feel let down by people I thought I could trust.	—	—	—
10 Most problems will go away if you ignore them.	—	—	—
11 People can avoid problems by planning their lives.	—	—	—
12 I think you can get most things you want if you try hard enough.	—	—	—
13 I've found people are generally very ungrateful for things you do for them.	—	—	—
14 You always have some freedom of choice, even in difficult situations.	—	—	—
15 I enjoy listening to other people and hearing about their experiences.	—	—	—

Score as follows:  
Questions 2, 5, 8, 11, 12, 14, 15: Y = 0, P = 1, N = 2  
Questions 1, 3, 4, 6, 7, 9, 10, 13: Y = 2, P = 1, N = 0

Results:  
Below 5: You are exceptionally resilient to crisis stress.  
5–10: You manage to face most crises successfully.  
11–15: You may find yourself knocked sideways by stress at times.  
Above 15: You are probably very vulnerable to the effects of crisis.

(Source: Parry 1990, p 53.)

Being aware of the influence of culture in the person's life will enhance the nurse's ability to care effectively. Indeed, this orientation is a responsibility of all professional mental health workers in Australia today (see, for example, Multicultural Mental Health Australia 2003). If a person is labelled suicidal, depressed or anorexic by professional staff this label may become a badge of shame for the family, who might then hide away. That in itself is bad enough but if the family hail from other parts of the world and English is not their first language then this experience may further alienate them and make successful integration much more difficult and less likely.

Culture has many layers and levels, and nurses cannot be expected to get a good grasp on all the relevant aspects of different cultural groups. However, nurses need at least a heightened awareness of the complex nature of culture and an attitude of openness and commitment in order to learn about it from individual clients. The need for such an attitude is illustrated in a study that explored Aboriginal perceptions of mental health and illness (Turale 1994).

Nursing interventions: attitudes and skills

Developing enhanced cultural sensitivity

Lorion & Parron (1985) described a number of studies that showed that if helpers or counsellors display low expectations of success with ethnic clients, the outcomes will also be low. Hence it is important for the counsellor or nurse to expect the client to be successful and to move forward. Also, for counselling to be effective, the boundaries for counselling need to be clearly established. These boundaries may come under close scrutiny when counselling any client, but especially one from a different culture, who may expect a friendship outside the formal parameters of the helping relationship.

When counselling clients from a different culture, verbal and non-verbal communication signs may be a major source of misunderstanding. It is important, therefore, for the nurse to spend time checking the accuracy of his or her understanding rather than assuming that they know what the client means. While the need to check for understanding is vitally important with clients from different cultures, it is also a core process in any helping situation. It is all too easy for the



nurse to assume that they know what the client means because they were both brought up in the same place. The need to check for understanding should not be overlooked. Poor communication generally tends to be the major source of complaints against healthcare staff (Audit Commission 1993).

A nurse from a similar cultural group to that of the client might be a useful resource, or they might be perceived as a threat to confidentiality, and hinder the development of a trusting relationship in which the client feels comfortable disclosing personal information (d'Ardenne & Mahtani 1989). In time, a trusting rapport could be established and this may not be an issue for the client, but if it continues to be problematic a different nurse should be invited to work with the client. It is important to note, too, that the nurse being a member of a professional group may help clients and family members to talk. The professional relationship allows them the space to talk about issues that could not be broached with relatives or friends.

It is also important to remember to take account of cultural aspects of people's lives when providing end-of-life care. Shrank et al (2005) explored the views of two culturally different groups in order to examine how cultural preferences influence decision-making. They found that non-Hispanic whites tended to be 'exclusive' and limited end-of-life discussions to closest family participants, while African-American participants opted for a more 'inclusive' approach extending to family, friends and spiritual healers.

### Helping clients deal with loss

A period of crisis, whatever its nature, often leads to a great sense of personal loss in those affected. A good helping relationship will allow the client to explore the loss and adapt to it more effectively. The primary purpose here is to try and facilitate a grief response following a major and significant personal loss. Grieving is a very natural process; experiencing grief is part of being human.

The death of a loved person is perhaps the most striking loss that most will experience. When caring for a person who has experienced such a loss it may be helpful to use the assessment framework outlined in the article by Cook & Dworkin (1992). They recommend that the nurse collect factual data about a person's particular situation, their social context and coping styles as well as more subtle aspects of the interaction such as non-verbal behaviour and the nurse's personal reactions to the client's story.

Some aspects of the nature of the relationship between people following a primary loss (wife, husband, child, lover, friend or colleague) will often emerge and need to be explored fully over time, along with the secondary losses that may have occurred. The secondary losses might involve changes in a client's social standing and friendships, changed relationships with children and so on. Other secondary losses might include changing roles and responsibilities, financial security, family

structures and companionship (Payne, Horn & Relf 1999). Within the framework of attachment theory, Bowlby (1980) argued that the stronger the attachment to the lost person (spouse, parent or child), the greater the intensity of distress for the client.

People may have different coping styles following a great loss in their lives. Some may not talk to anyone about their loss for some time. They may experience strong feelings of depression, anger, resentment and low self-worth and may have thoughts of suicide. Others may not express the pain and grief from the loss openly but suppress these feelings over time to avoid being seen as 'wounded', 'abandoned' or a 'failure' in relationships. It is important to be able to express the pain and anger that follows a significant personal loss. Accepting the loss is one of the key tasks in mourning (Worden 2001) and this acceptance then enables the client to work on the pain of grief and make adaptive adjustments (Payne et al 1999).

Some elements of the physical impact of the loss can emerge—lack of sleep, poor eating pattern and associated weight loss. In addition, the influence of religion, spirituality and available support systems will be important elements in determining how an individual copes. These would also form important facets of any good assessment.

Personal loss comes in many forms—loss of a spouse, a child, a parent, a pregnancy, a companion animal—and the significance of these losses can spark a crisis in people's lives. Children and adolescents experience losses too (parents, grandparents, sisters, brothers or friends) and may need even more creative support to help them express their pain and distress.

A sad story can induce sadness and stimulate reflection about the ways people sometimes treat each other and how lonely it must be to face a crisis and its aftermath (a marriage separation, domestic violence, sexual abuse, suicide in the family). This reaction is something that the nurse should discuss with a supervisor or mentor.

### Being there for the client

It is important to spend time with the client and allow them to tell their story. At this time strong feelings may be evoked and this is often one of the most testing times for a nurse—not knowing what to say or do. Being there and listening attentively is of great value. It is important not to try and rescue the client from the pain or distress that is being described. Try to be a 'companion' and 'walk alongside the client' in a 'meaningful relationship' (Geldard 1998). This approach will help to ensure that the pace of the session is appropriate and unrushed. Many important emotional reactions can be unpacked and may need to be revisited later on. It is important for the client to remain in the driving seat and for the nurse to follow them.

### Allowing the client to express emotional pain

It is usually helpful to allow the client the time and space to work with their feelings if they raise them

in the session. Sometimes just being silent will signal to the client to pick up the threads again and expand on these in their own way and in their own time. It is important to try to avoid 'normalising' the feelings a client expresses, while acknowledging and validating their feelings. It will be helpful to reflect the client's feelings, to build empathy at several points during the session (e.g. 'You felt abandoned'–'worthless'–'in great pain'). These help to acknowledge the strong feelings that the client is experiencing or has felt in the past (see Ch 23 for further discussion of communication skills).

### **Being sensitive to cultural considerations in death and dying**

There are some important cultural differences with respect to death and dying that a nurse must be aware of when helping clients and their families. These differences shape the way people view the world: 'From an anthropological perspective, members of a society view the world in a similar way because they share the same culture; people differ in how they view the world because their cultures differ' (Robbins 1997, p 4). In commenting on the attitudes to death and dying that are prevalent in Western societies, Kübler-Ross (1981) argued that people in Western societies tend to spend a great deal of time denying the reality of death, as seen in the euphemisms employed to describe a dead person. This is not so in other societies, where death is accepted as part of the cycle of life.

Regardless of the cultural setting and experiences, each person's grief is individual and each person will react differently to bereavement. People need to retain their individuality in a professional helping setting to ensure that they grieve in their own appropriate way (McKissock 1992). Nevertheless, Worden (2001) argues that despite cultural differences, and individual reactions to death and dying, a common theme is the wish to regain the lost person and the belief that the dead person will be met again in some form of afterlife.

### **Acknowledging the meaning of death and dying in different cultures**

The meaning assigned to events and experiences shapes people's view of the world and tells them how to react to death and dying in culturally expected ways. In some groups, death marks the passage from one world to another, while for others death is an ending or part of a cycle of birth, death and rebirth (Robbins 1997). For example, the Kwakiutl of British Columbia believe that a dead person's soul leaves the body and enters the body of a salmon. The soul is later released and is free to enter the body of another person when the salmon is caught and eaten.

Robbins (1997) describes a number of cultural differences to indicate how some societies fear the dead, while others revere them. The traditional Chinese household may construct shrines to family ancestors whose advice is sought when important family decisions

are faced. The dead become part of the world of the living. This is common in many Japanese and other Asian families (Johnson 1987). In contrast, in Southern Italy, useful objects such as coins are placed near the dead person to discourage them from returning to disturb the living.

Culture provides a social context for the actions of survivors. Public outpourings of grief and mourning may characterise grieving and lead to culturally expected behaviours. In other cultures such overt displays of emotions may be seen as embarrassing. The Dani of New Guinea expect a close female relative of the deceased to sacrifice part of a finger, while Southern European widows were expected to shave their heads. In traditional times, when North American Apaches died, their shelters and homes were burned down; in traditional India, widows were cremated at their husbands' funerals (Robbins 1997).

These culturally appropriate beliefs and behaviours are in stark contrast to what is expected at a funeral in Australia, the United Kingdom or the United States, where 'survivors of the deceased are expected to restrain their grief almost as if it were a contagious disease' (Robbins 1997, p 6). This is especially so for men in Western society, who have been socialised to believe that open expressions of emotion are unacceptable. In contrast to this expectation, a death in a Jewish community is considered to be a public loss and is shared with the community. The family of the deceased person becomes the focus of community attention and the community shares responsibility for the burial and the care of the bereaved family.

Some cultures accept death as a natural and inevitable process, while others perceive it to be caused by some form of sorcery that must be met with acts of vengeance. Sometimes these culturally appropriate beliefs and behaviours elicit a sense of disbelief in someone from another culture and may even lead a health professional with a Western orientation and training to conclude that the bereaved person is mentally ill. For example, the Chewa of Malawi in Africa believe that illness and death are the result of sorcery and that there is a link between sorcery and social tension. If people disagree on important issues they may practise sorcery against each other (Robbins 1997). If the relative of a deceased person were to make claims of this nature to their Western GP, they might be referred to a psychiatrist for antipsychotic treatment.

Although death is universal, people's responses to death can be shaped by culture (DeSpelder & Strickland 1992). For example, the type of death can be problematic and perceived differently. In many cultures, suicide is one of the most difficult things for survivors to accept; yet in Japan, suicide may be seen as an honourable way to die (Moos 1995). Understanding some of the cultural perspectives that exist can help counsellors and nurses to be more open in their attitudes to clients from different cultures. Cultural reactions to death and dying are extremely diverse and multifaceted.

Accepting and understanding this diversity can lead to a non-judgmental attitude and genuine helping for the client.

Not to be aware of some of the deeply rooted cultural customs surrounding a particular death may give the impression that the nurse of a bereaved client is not genuinely concerned about the client, and this could cause further distress. An attitude of flexibility and sensitivity is vitally important (Sherr 1989). This attitude is also sensible, as the nurse cannot possibly know everything about every religious group. In addition, the diversity is further complicated by the way individual clients may respond to a death in a particular case (Sherr 1989). The nurse must be *prepared*—seeing others in despair may trigger despair in the nurse too.

Finally, it is important to remember, especially in a multicultural country like Australia, that many people identify strongly with their traditional cultural background at times of crisis, much more so than at other times in their lives (Cook & Dworkin 1992). This may be a source of structure and emotional strength for them but it may also elicit personal conflicts and feelings of guilt about neglecting the values or religious practices that were so important at an earlier age. It may be difficult for those around them to accept this change (see also Chs 6 and 7).

### Acknowledging difficulties

Professional nurses need to acknowledge their difficulty in understanding other people's perspectives on life crisis, loss, death and dying, especially if those perspectives are far removed from their own core values. A nurse who develops a better awareness of the impact of culture is in a much better position to make a thorough assessment of the client experiencing bereavement and other types of loss. The assessment should include a description of the cultural beliefs and experiences of the client and how they responded to any similar losses in the past. It should clarify how the loss and other secondary losses will affect the client's life. It is important that the nurse or helper does not transfer their own cultural beliefs and values back onto the clients and their families (Sherr 1989).

The nurse who has a good understanding of the client's cultural background is in a much better position to decide whether the grieving is normal or abnormal. Worden (2001, p 34) noted that if counsellors are to make accurate predictions about how a person will grieve, they need to know 'something about the social, ethnic and religious background of the survivor'. For example, if a client has been socialised not to speak ill of the dead, they may be unable to express the anger they feel towards a deceased relative, and the counsellor will have to work with the client to help them to arrive at and express a 'balanced' perspective.

People from other (non-Western) cultures may be less likely to seek out professional help for fear of 'losing face' in their own community. Even if they do, they may be less trusting of the helper because their

culture has taught them not to rely on outsiders. In contrast, a helper who is close to the client culturally may be perceived as a threat to confidentiality and this may have a negative impact on the process, making it difficult to establish a trusting relationship in which the client feels comfortable disclosing personal information (d'Ardenne & Mahtani 1989).

It is important also to note that the relationship aspects of the process will remain crucial whatever cultural factors come into play. Horvath (1995, p 12) described a meta-analysis that explored the relationship between the quality of the alliance the therapist has with their client and the outcome of therapy, over a fifteen-year period. He noted that the quality of the alliance was a 'robust predictor of therapy outcome'. Nurses who expand their counselling role will need to ensure that relationships with their clients have an appropriate affective/emotional bond. This may be harder to establish and maintain when caring for someone with a different cultural background.

Finally, the nurse who is committed to his or her clients may then feel overwhelmed and emotionally exhausted by despairing clients and families in crisis. As a result, the nurse will not be able to help clients effectively and the nurse's own health will suffer. To guard against this, the nurse will need to work with colleagues who can provide some form of supervision and debriefing so that suitable boundaries between the nurse and those seeking help are established. This will also help the nurse to achieve greater clarity in the helping process and ensure that the client's issues are being addressed.

### Exploring opportunities for advanced training

Dealing with crisis requires great skill, and nursing interventions can be enhanced with advanced training. Some of the theoretical frameworks developed in other areas, notably psychology and counselling, are very well suited to the nursing practice context (see, for example, Barker 2003 and Watkins 2001). Some approaches that offer great scope in this area are the person-centred approach to counselling following Carl Rogers (Merry 2000), the gestalt approach developed by Frederick Perls (Ellis & Leary-Joyce 2000) and the narrative approach espoused by Michael White (Payne 2000).

The use of suitable theoretical approaches provides a framework for providing comfort to the client (and their family) and addressing the intense feelings associated with a crisis. They will also help the client to clarify events and preferred options in their life, and to identify the primary resources and sources of support available to them. In short, they will help the client to be the author of their own life and to strive to live in the way that they prefer. Nursing interventions that are underpinned by appropriate counselling and therapy theory can be of great help to the client as they strive to adapt effectively to a crisis in their life.

## A PERSONAL NARRATIVE

In my weekly practice as a psychologist I regularly see people who are dealing with significant personal distress and losses in their lives. These losses take many forms: fractured or changing relationships leading to unfulfilled lives; loss of unrealised potential through the onset of a serious mental illness; loss of identity through sexual or psychological abuse; loss of career opportunities; loss of a partner or child through unexpected death. Although I see distressed people most weeks, I rarely feel burdened by the work.

This work teaches me to have a new appreciation of life and the gifts it provides. I often find clients' stories of how they dealt with loss inspiring and filled with hope and sometimes humour.

This helps me to avoid making judgments about people generally, to view the world with 'softer' eyes and to have a greater appreciation of people. It helps me to be influential and helpful but to also be acutely aware of the fact that it is the clients who do the work and make changes in their lives, not me. There are of course occasions when my relationship with a client does not work, and I do find this hard. I find it helpful to talk about the positive and negative aspects of this work with supportive colleagues, to continue to develop myself professionally through study and therapy workshops, and to go to the gym every week.

### CRITICAL THINKING CHALLENGE 10.3

Careen (42 years old) is a qualified architect and partner in a busy city office. She is an attractive woman with an intermittent history of bipolar disorder and has been happily married to James for twenty years. They have two daughters: Siobhán (17) and Oonagh (15). It is clear that the family love Careen very much and when she has been ill, they have coped admirably. On this occasion, Careen has had to be admitted to hospital because she has not been sleeping and her behaviour has become more erratic and unpredictable—driving recklessly and putting people at risk, threatening to kill a shop assistant when he responded rudely to her, turning up for work at 3.30 in the morning with no clothes on, and being sexually provocative with strangers. The level of disinhibition she displayed was such that she was assessed by the crisis team as being a risk to herself and others and was admitted to the acute unit on a short-term basis.

David is a registered mental health nurse of some years' experience. He is very conscientious and has a very good rapport with clients, their families and other healthcare professionals. He is currently studying for a Master's degree and is in charge of the unit on night duty. When doing his rounds of the unit at 5.30 am he found Careen having unprotected sex with Nick in her room. Nick has a long history of mild depression, alcohol and intravenous drug abuse.

- What should David do to care for Careen and her family in the coming weeks?
- Who should be informed about the incident? What guidelines could David use to structure his choices and decisions?

## Conclusion

Dealing with crisis is a normal part of life for everyone. Nurses, however, will be exposed to crisis and its aftermath on a regular basis, no matter what area of nursing they specialise in. Nursing exposes its practitioners to the pain and suffering that unfolds daily in other people's lives. It does so in an intense way and sometimes over a very short and compressed period of time. This level of exposure will elicit attendant emotional reactions and upset in the nurse and others. Nurses also have to learn to cope with the stressful events in their own lives that emerge from time to time. These

can interfere with the nurse's ability to help others, so it is important to make sure they are dealt with in order to limit their impact on work-related issues.

Learning to cope with crisis and respond positively through enhanced self-awareness, the development of specialist counselling skills and increased cultural sensitivity will not only help the nurse to function more effectively at work, but will also help the nurse to stay healthy. To conclude, it is important to remember that people do survive even the most harrowing of experiences and existences. It might help to do further reading in the area, such as the most remarkable account of survival found in Dave Pelzer's *My Story*—three books in one describing his journey of survival from the most horrifying abuse by his alcoholic mother (Pelzer 2002). These stories are inspiring reading for any health professional.

## EXERCISES FOR CLASS ENGAGEMENT

- *When written in Chinese the word 'crisis' is composed of two characters. One represents danger and the other represents opportunity.*

John F. Kennedy

*You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You are able to say to yourself, 'I lived through this horror. I can take the next thing that comes along.' You must do the thing you think you cannot do.*

Eleanor Roosevelt

Take a pencil and a sheet of paper. Write a short summary of a particular crisis in your life. Describe the event or time and recall how you felt and how you responded to it. See if you can name the people who were most helpful. What did they do or say that helped you to get through? What particular skills, competencies or personal qualities did you find in yourself that helped you to get through this crisis period? How has the experience enhanced your coping skills since then?

Share this story with your group, and together consider how your experiences might help or hinder your ability to help people in crisis.



- Seán and Conor were brought up in a small, staunchly Catholic and conservative town where everyone went to Mass on Sunday and most families knew each other well. They had known since their early teens that they were both gay but had not disclosed this to family members or teachers. Feeling greatly burdened and out of step with the community, they decided to speak to the Parish priest and told him about their sexual orientation. The priest chased them out of his house and told them that they would both 'roast in Hell'. Seán and Conor stopped going to Mass and soon after left the town for city life, returning only for occasional visits to their families.

- How might this reaction to their disclosure have affected the lives of Seán and Conor?
- Consider how you might respond if a close friend or relative made this type of disclosure to you.

- Briefly describe a few changes and losses other than the death of someone close to you, that you have experienced in the past few years.

- With your group, discuss some of the ways in which each type of loss is similar to and yet different from the other. List commonalities and unique aspects of each loss.
- See if you can identify any secondary losses.

- *Two cars were being driven fast and in opposite directions along a winding country lane. It was late summertime, and the hedgerows on either side of the lane were lush and high. It was impossible to see around any of the corners.*

*Both drivers, because of the heat of the day, had their windows wound down, and their minds were focused on the road ahead and their destination. And, as it happened, the driver of one of the cars was a man and the other was a woman.*

*They approached the final bend at speed, and they only just managed to see each other in time. They slammed on their brakes and just managed to slide past each other without scraping the paintwork.*

*As they did so, the woman turned to the man, and through the open window she shouted, 'PIG!'*

*Quick as a flash the man replied, 'COW!'*

*He accelerated around the corner . . . and crashed into a pig.*

(Source: Rabbi Lionel Blue, on 'Thought for the Day', BBC Radio 4, Today Programme. Cited in: Owen N 2001, *The magic of metaphor*, Crown House Publishing, Carmarthen.)

- Can you think of a time when you assumed something to be the case and found out later that you were wrong? How did you cope with that?
- What kinds of assumptions might you make when caring for someone from a different cultural background to yours? Or that they might make about you? What difficulties might arise as a result? How could such issues be managed effectively by nurses and other healthcare workers? Share your findings with your group.
- Deirdre (46) was an enrolled nurse and single parent of two identical twins, Gavin and Tim. She worked in casualty for many years on night duty alongside a very good team of staff. There was a really good supportive atmosphere in the unit and they were collectively a very competent emergency team. On the night of their 21st birthday Gavin and Tim went out partying and borrowed Deirdre's car while she was working.

At 2 a.m. three ambulances arrived at the casualty following a high-speed collision on the freeway. A number of people were

killed and others were seriously injured. As the casualty staff helped to unload the ambulances, Deirdre saw the bodies of her two sons in the back of one of the ambulances, and fainted.

Write down your responses to the following questions and then share these in the larger group setting:

- What emotions would be elicited in Deirdre and her colleagues by this shocking trauma?
- How do you think you would have felt if you were one of Deirdre's colleagues that night?
- How could the team help Deirdre to deal with these events initially and in the following weeks?
- What particular resources or activities might prove helpful for Deirdre and the team in the healing process?
- How could the staff deal with the 'awkward' feelings they experience around Deirdre when she returns to work several weeks later?
- What would you like to take with you from this story that might be help you in your future clinical work? Why are these important to you? What do they suggest about the type of nursing professional you aspire to be?

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